



TEXAS DEPARTMENT OF INSURANCE

Division of Workers' Compensation - Medical Fee Dispute Resolution (MS-48)

7551 Metro Center Drive, Suite 100, Austin, Texas 78744-1645

(512) 804-4000 | F: (512) 804-4811 | (800) 252-7031 | TDI.texas.gov | @TexasTDI

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name

Mary F. Terrell, M.D.

Respondent Name

Texas Mutual Insurance Company

MFDR Tracking Number

M4-15-4173-01

Carrier's Austin Representative

Box Number 54

MFDR Date Received

August 26, 2015

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "We are billing a total of \$1,200.00 for these services. *We have received a payment of \$750.00 from your company.* **Please issue prompt payment in the amount of \$450.00 to settle this claim.**"

Amount in Dispute: \$400.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "The following is the carrier's statement with respect to this dispute. This requestor billed code 99456-W6/Re, extent of injury exam. The DWC32 does not list that exam as one requested. For that reason Texas Mutual declined to issue payment Texas Mutual will issue payment for the specialist report."

Response Submitted by: Texas Mutual Insurance Company

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
March 4, 2015	Designated Doctor Examination	\$400.00	\$0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and applicable rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §133.20 sets out medical bill submission procedures for health care providers.
3. 28 Texas Administrative Code §133.250 sets out the procedures to request a reconsideration for payment of medical bills.
4. 28 Texas Administrative Code §102.4 sets out the rules for non-Commission communications.

5. Texas Labor Code §408.027 sets out the rules for timely submission of claims by health care providers.
6. Texas Labor Code §408.0272 provides for certain exceptions to untimely submission of a medical bill.
7. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
 - CAC-29 – The time limit for filing has expired.
 - 731 – Per 133.20(B) provider shall not submit a medical bill later than the 95th day after the date of service.

Issues

1. What is the timely filing deadline applicable to the medical bills for the services in dispute?
2. Did the requestor forfeit the right to reimbursement for the services in dispute?

Findings

1. While CPT code 99456-W5-WP for \$350.00 and 99456-SP for \$50.00 were included on the Medical Fee Dispute Resolution Request (DWC060), the requestor is seeking \$0.00 for these services. Therefore, these codes will not be considered in this dispute.

28 Texas Administrative Code §133.20(b) requires that, except as provided in Texas Labor Code §408.0272, “a health care provider shall not submit a medical bill later than the 95th day after the date the services are provided.” No documentation was found to support that any of the exceptions described in Texas Labor Code §408.0272 apply to the services in this dispute. For that reason, the requestor in this dispute was required to submit the medical bill not later than 95 days after the date the disputed services were provided.

2. Texas Labor Code §408.027(a) states, in pertinent part, that “Failure by the health care provider to timely submit a claim for payment constitutes a forfeiture of the provider’s right to reimbursement for that claim for payment.”

28 Texas Administrative Code §102.4(h) states that “Unless the great weight of evidence indicates otherwise, written communications shall be deemed to have been sent on: (1) the date received, if sent by fax, personal delivery, or electronic transmission or, (2) the date postmarked if sent by mail via United States Postal Service regular mail, or, if the postmark date is unavailable, the later of the signature date on the written communication or the date it was received minus five days. If the date received minus five days is a Sunday or legal holiday, the date deemed sent shall be the next previous day which is not a Sunday or legal holiday.”

28 Texas Administrative Code §133.250 (d) states, “A written request for reconsideration shall: (1) reference the original bill and include the same billing codes, date(s) of service, and **dollar amounts as the original bill**” [emphasis added].

Review of the submitted information finds no documentation to support that a medical bill for the services in question was submitted within 95 days from the date the services were provided. Therefore, pursuant to Texas Labor Code §408.027(a), the requestor has forfeited the right to reimbursement due to untimely submission of the medical bill for the disputed services.

Conclusion

For the reasons stated above, the Division finds that the requestor has not established that additional reimbursement is due. As a result, the amount ordered is \$0.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to \$0.00 reimbursement for the disputed services.

Authorized Signature

Signature

Laurie Garnes
Medical Fee Dispute Resolution Officer

September 17, 2015
Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute has a right to seek review of this decision in accordance with 28 Texas Administrative Code §133.307, 37 *Texas Register* 3833, applicable to disputes filed on or after June 1, 2012.

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the Division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the Division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MFDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.